HOW TO FILE YOUR DEPENDENT CARE ACCOUNT REIMBURSEMENT CLAIM

This form is to be used only to request reimbursement for dependent care expenses. To view a detailed list of eligible dependent care expenses, visit **www.myshps.com**. In general, and subject to the rules of your employer's plan, the following rules apply to dependent care expenses:

- The individual receiving care must be either a qualifying child or a qualifying relative. (see below for IRS definition of dependent)
- The individual must be under the age of 13 unless he or she is physically or mentally unable to care for himself or herself.
- The expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school on a full-time basis.
- Child care or elder care centers must comply with all applicable state and local laws in order for dependent care expenses to be reimbursed.
- The annual amount of dependent day care claims cannot exceed your annual deposit amount up to (a) $5,000, (b) $2,500 if married and filing separate returns, or (c) your or your spouse's annual salary, if less than $5,000.

Step 1: Fill out the form

- Please print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

- Complete all sections of the claim form. Sign and date the bottom of the form.
- If your claims exceed the number of lines provided, please use page 3 for additional claim.

Step 2: Attach supporting documentation

- Copy your receipts or other supporting documentation onto a white, letter-sized sheet of paper. Place your receipts so they all face the same direction. And write your Social Security Number at the top of the page.

Step 3: Submit your claim (Faxing is faster)

- By Fax: Send the claim and copied receipts as one multi-page fax. Do not include a fax cover sheet. If you provide your e-mail address, SHPS will e-mail you confirmation we received your claim.
- By Mail: Place the form and the supporting documentation into an envelope, apply the correct postage, and mail.
- Keep a copy of your completed claim form and receipts throughout the plan year.

Step 4: Receive your reimbursement (Direct Deposit is faster)

- By using Direct Deposit or Electronic Funds Transfer (EFT), you'll receive your reimbursement funds up to five days faster than by receiving a check. To sign up, log in to your account at **www.myshps.com** and select "Direct Deposit Sign-Up" from the left-side menu.

Type of Supporting Documentation:

You must include supporting documentation for your dependent care expenses with your claim. Attach a copy of the bill or signed receipt, or have the provider sign the Affidavit on Section 2 of the claim form. Claims without the Tax ID number for all providers will be denied.

Please Do Not:

- Use red ink
- Use a photocopy of the form
- Highlight receipts or any part of the claim form
- Staple your copied receipts to the claim form
- Write outside the boxes provided
- If faxing, fax the same claim more than once
- Mail the same claim that you have faxed
- Include this instruction sheet with your fax

New IRS Tax Dependent Definition:

A recent change to the Internal Revenue Code revised the definition of "dependent." Generally speaking, a qualifying child must reside with you for more than half the year and must not provide over half of his/her own support. A qualifying relative is an eligible individual if (1) you provide more than half of the individual's support, and (2) the individual is not a qualifying child of you or any other taxpayer, and (3) the individual's gross income is less than $3,200 in 2005. **Please note that any questions regarding the status of an individual as either a qualifying child or a qualifying relative must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.**

REIMBURSEMENT CLAIM FORM – DEPENDENT CARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals, and don't use red ink.

FAX CLAIMS TO: 1-866-643-2219 TOLL FREE

For additional claim requests, please use next page.

ZDZCZRZ

Reset Form

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID

COMPANY NAME

STATE OF MARYLAND

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

FOR SHPS ONLY

EMPLOYEE EMAIL

DAYTIME PHONE #

SECTION 2: YOUR DEPENDENT CARE CLAIMS

CLAIM 1

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:

Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.

I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____

SECTION 3: CERTIFICATION

Please read Certification Statement thoroughly before signing.

I hereby certify that:

- The information contained within this claim is correct; and
- I have not received reimbursement previously for these expenses from my Flexible Spending Account or any other plan and will not seek reimbursement by any other plan; and
- The total of any reimbursed dependent day care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than $5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free; and
- Reimbursement of dependent day care expenses will reduce and may eliminate completely my ability to claim a dependent day care credit on my personal income tax return;
- Dependent day care expenses reimbursed through this account cannot be used as a dependent day care credit on my personal tax return; and

I hereby authorize release of payment through my Flexible Spending Account.

I hereby authorize SHPS or its representatives to obtain necessary information from all dependent day care providers and other agencies or organizations to consider the claim for reimbursement under my Flexible Spending Account.

FAX: 1-866-643-2219 Toll Free

MAIL: SHPS FSA Administration
PO Box 34700
Louisville, KY 40232

PHONE: 1-877-358-4276

Employee Signature _____ Date _____

ZDZCZRZ

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

Reset Form

USE THIS PAGE FOR ADDITIONAL DEPENDENT CARE CLAIMS.

FDFTFWF

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

SECTION 5: YOUR ADDITIONAL DEPENDENT CARE CLAIMS

CLAIM 2

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:
Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____

CLAIM 3

START DATE OF SERVICE (MMDDYY)

PROVIDER TAX ID OR SSN

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

END DATE OF SERVICE (MMDDYY)

DEPENDENT #1 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #1 NAME _____

DEPENDENT #2 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #2 NAME _____

DEPENDENT #3 DATE OF BIRTH (MMDDYYYY)

DEPENDENT #3 NAME _____

AFFIDAVIT:
Your day care provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE _____ DATE _____